



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PPMC
P.O.BOX 5607
PASADENA, TX 77508

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

AMERICAN HOME ASSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-12-0133-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary from Table of Disputed Services: "Past the time limit for filing an appeal All claims were submitted to the insurance in a timely matter."

Amount in Dispute: \$653.13

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Chartis requests the Division of Workers' Compensation Medical Review Division dismiss this request for Medical Dispute Resolution as it was not filed timely per DWC Rule 133.307(c)(1). The Requestor billed \$653.13 but payment was denied as the bill was not received until 03/18/11. ...The bill was not received timely causing payment to be denied. Chartis request that you find Omar Vidal, M.D. is not due a reimbursement for this date of service."

Response Submitted by: Chartis, 4100 Alpha Rd., #500, Dallas, TX 75244

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 19, 2004	62290	\$653.13	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated March 28, 2011

- 1-29-The time limit for filing has expired.
- 1-Date(s) of service exceed 11 month time period for submission per Rule 134.801C
- 2-172- Payment is adjusted when performed/billed by a provider of this specialty.
- 2-Level II Temporary Exception Certified Provider.

Explanation of benefits dated April 15, 2011

- No denial codes listed on EOB.

Issues

1. Did the requestor file for dispute resolution in accordance with 28 Tex. Admin. Code §133.307?
2. Is the requestor eligible for medical fee dispute resolution under 28 Tex. Admin. Code §133.307?

Findings

1. Per 28 Texas Administrative Code §133.307 (c)(1)(A) states in pertinent part that a request for medical fee dispute resolution shall be filed no later than one year after the date(s) of service in dispute. The date of service in dispute is 11/19/2004. The request for dispute resolution was received in the Medical Dispute Resolution (MDR) section on 09/13/2011.
2. 28 Texas Administrative Code §133.307 (c)(1) states that a requestor shall timely file with the Division's MDR Section or waive the right to medical dispute resolution. The Division finds that the requestor has failed to timely file this dispute with the Division's MDR Section and has therefore waived the right to medical dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	October 14, 2011
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.